



HANDBOOK FOR PROVIDERS OF SCHOOL BASED/ LINKED HEALTH CENTER SERVICES

CHAPTER S-200 POLICY AND PROCEDURES FOR SCHOOL BASED/ LINKED HEALTH CENTERS

CHAPTER S-200

SCHOOL BASED/LINKED HEALTH CENTER SERVICES

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FOREWORD

PURPOSE

This handbook has been prepared for the information and guidance of providers who provide School Based/Linked Health Center (SBLHC) services for participants in the Department's Medical Programs. It also provides information on the Department's requirements for provider participation and enrollment.

This handbook can be viewed on the Department's website at

<http://www.state.il.us/dpa/handbooks.htm>

This handbook provides information regarding specific policies and procedures relating to SBLHC services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's website at

http://www.state.il.us/dpa/medical_programs.htm

Providers will be held responsible for compliance with all policy and procedures contained herein.

Inquires regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 217-782-5565.

CHAPTER S-200

SCHOOL BASED/ LINKED HEALTH CENTER SERVICES

S-200 BASIC PROVISIONS

For consideration to be given by the Department for payment of SBLHC services, such services must be provided by a provider enrolled for participation in the Department's Medical Programs. This handbook is intended to be used in conjunction with the Handbook for Providers of Medical Services, Chapter 100, General Policy and Procedures (Chapter 100), the Handbook for Physicians, Chapter A-200, and the Handbook for Providers of Healthy Kids Services, Chapter HK-200. The Handbook for Physicians includes guidelines and specific billing procedures applicable to providers of primary care services. Exclusions and limitations are identified in specific topics contained herein.

S-201 PROVIDER PARTICIPATION

School Based/Linked Health Centers must be certified by the Illinois Department of Human Services (IDHS) and meet the standards established by IDHS in 77 Ill. Adm. Code, Part 2200. The rules may be viewed on IDHS's website at

<http://www.state.il.us/agency/dhs/Rules/ad2200.pdf>

S-201.1 PARTICIPATION REQUIREMENTS

A SBLHC certified by IDHS is eligible to be considered for enrollment to participate in the Department's Medical Programs.

PROCEDURE: The provider must complete and submit:

- ☐ Form DPA 2243 (Provider Enrollment/Application)
- W9 (Request for Taxpayer Identification Number)
- ☐ Form DPA 1413 (Agreement for Participation)

The following documentation must be provided with the application.

- ☐ CLIA Certificate (if the center provides laboratory services)
- ☐ IDHS Certification Letter

The enrollment application must be obtained from:

Illinois Department of Human Services
Office of Family Health
535 West Jefferson
Springfield, Illinois 62702-5058
(217) 785-4525

The forms must be completed (**printed** in black ink or typewritten), signed and dated in ink by the provider, and returned to the above address. IDHS will attach the certification letter and forward all documents to the Department for enrollment. The provider should retain a copy of the forms. The date on the IDHS certification letter will be the effective date of enrollment.

Participation approval is not transferable - When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

S-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, refer to Appendix A-7 in the Handbook for Physicians. The School Based/Linked Health Center will be enrolled as a **Provider Type 56**.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic S-201.4.

S-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten calendar days after this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

S-201.4 PROVIDER FILE MAINTENANCE

The information carried in Department files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Anytime the provider effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of the change.

PROCEDURE: The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or a change is submitted by the provider, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to any payees listed if the address is different from the provider.

S-202 SCHOOL BASED/LINKED HEALTH CENTER REIMBURSEMENT

S-202.1 CHARGES

Charges billed to the Department are to be the provider's usual and customary charges to the general public for the services provided. Providers may only bill the Department **after** the service or item has been provided. All services for which charges are made must be coded with the specific procedure codes listed on the Department's website. Refer to Topic S-202.5.

S-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Topic 112.3.

Providers billing electronically should take special note of the requirement that Form DPA 194-M-C, Billing Certification Form, must be signed and retained for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form DPA 194-M-C can be found on the last page of each Remittance Advice which reports the disposition of any electronic claims. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for the provider to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

S-202.3 CLAIMS PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedure regarding claim submittal. Form DPA 2360, Health Insurance Claim Form, must be used to submit charges for all services provided by the School-Based/Linked Health Center. For detailed instructions for completion of the DPA 2360 and a copy of the claim form

refer to Appendix S-1.

The Department uses a claim imaging system to scan paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. The Department offers a claim scannability and imaging evaluation. Please send sample claims with a request for evaluation to the following address:

Illinois Department of Public Aid
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

S-202.31 Claims Submittal

All routine paper claims are to be submitted in a pre-addressed envelope provided by the Department for this purpose, Form DPA 1444, Provider Invoice Envelope. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim, use DPA 1414, Special Approval Envelope. A non-routine claim is:

- Any claim to which Form 1411, Temporary MediPlan Card, is attached.
- Any claim to which any other document is attached.

S-202.4 PAYMENT

Payment made by the Department for allowable services provided will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the Department, and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

S-202.5 FEE SCHEDULES

The Department's maximum reimbursement rates for the allowable procedures are

listed on the Department's website. The listing can be found at:

<http://www.state.il.us/dpa/html/medicaidreimbursement.htm>

Paper copies of the listing can be obtained by sending a written request to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
201 South Grand Avenue East
Springfield, IL 62763-0001

The maximum rates, quantity limitation and prior approval requirements for each service or item are available electronically. The Department maintains a downloadable rate file suitable for use in updating a provider's computerized billing system. This file is located in the same area on the Department's website as the listing described above. A copy of this file can also be obtained by sending a blank 3.5 inch IBM PC compatible diskette, a written request and a self-addressed, prepaid diskette mailer to the address listed above.

The website listings and the downloadable rate file are updated annually. Providers will be advised of major changes via a written notice. Provider notices will not be mailed for minor updates such as error corrections or the addition of newly created Health Care Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes.

S-203 COVERED SERVICES

A covered service is a service for which payment can be made by the Department.

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

Services listed below are reimbursable services when provided in a SBLHC setting:

Basic Medical Services such as;

- EPSDT Services as defined in the Handbook for Providers of Healthy Kids Services, Chapter HK-200
- Immunizations
- Basic Laboratory Tests
- Screening and Treatment of Sexually Transmitted Diseases
- Family Planning Services
- Acute Management and on-going monitoring of chronic conditions, such as asthma, diabetes and seizure disorders
- Maternity Care (Prenatal and Postpartum)
- Dental Services -The Department contracts with Doral Dental Services of Illinois to manage the dental program. If the center provides dental services, contact Doral Dental at 1-888-286-2447.

The Department's list of allowable procedures for SBLHCs are listed on the Department's website at:

<http://www.state.il.us/dpa/html/medicaidreimbursement.htm>

Refer to S-202.5 for more information regarding the Department's fee schedules on the Website.

S-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs.

Certain services provided by the center are not reimbursable by the Department to the SBLHC. The services include but are not limited to:

- Ⓒ The Office of Mental Health (OHM) or the Office of Alcoholism and Substance Abuse (OASA) Services. When the center determines these services are required, a referral may be made to the appropriate resource. Refer to the Handbook for Providers of Healthy Kids Services for the policy and procedures for the referral, as well as a list of referral resources.
- Ⓒ Any medical services not listed on the Department's website for SBLHCs must be referred to the Managed Care Organization (MCO), a primary care provider or other appropriate source of medical care.
- Services provided off-site (not at the SBLHC site) cannot be submitted for reimbursement using the SBLHC's provider name and the provider number assigned by the Department.

S-205 RECORD REQUIREMENTS

The Department regards the maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are a key document for post payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

In the absence of proper and complete medical records, no payments will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

Providers must maintain an office record for each patient. The basic record must include:

- C Identification of the patient (name, address and recipient identification number)
- C History and physical examination findings
- C Diagnostic and therapeutic orders
- C Health care provider's notes with an appropriate signature
- C Laboratory results
- C Needs assessment and referrals
- C Consent form if appropriate

The record must include the essential details of the patient's health condition and of each service provided. All entries must be dated, legible and in English. Records which cannot be audited because of illegibility may result in sanctions if an audit is conducted.

S-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED MEDICAL DIAGNOSTIC AND TREATMENT SERVICES

Except as noted in this handbook, medical diagnostic, treatment and preventive services performed at the SBLHCs are subject to the policies and procedures contained in the Handbook for Physicians, Chapter A-200 and the Handbook for Providers of Healthy Kids Services, Chapter HK-200.

NOTE: If the participant is enrolled with a Managed Care Organization (MCO), it is the center's responsibility to assure that all necessary follow-up, drugs and treatment are coordinated with the MCO.

S-210.1 PROTOCOL

The protocol is the written instrument which defines the relationship between the physician and other health care professionals at the center and identifies the medical services to be provided within the scope of each practitioner's expertise. The annual review must be written, maintained on file at the center and be available upon request by Department staff. Health care professionals are defined as a resident physician, advanced practice nurse, physician assistant and registered nurse.

The Protocol on file must meet the following guidelines:

- C The written document reasonably describes the kind of services to be provided and, as appropriate, criteria for referral and consultation with the physician.
- C The document must specify which authorized procedures do not require a physician's presence as the procedures are being performed.
- C The document must specify arrangements for communication with a physician for services that are outside of the established protocol.

All services submitted for payment to the Department that are provided by a resident physician or a registered nurse must have the physician's countersignature in the medical record.

S-210.2 MATERNITY CARE

To provide prenatal and postpartum care at the center, the center must arrange for or have an agreement with a physician who has delivery privileges. For complete maternity care policies refer to Chapter A-200, the Handbook for Physicians, Topics A-290 and A-291.

S-210.3 PROCEDURE CODES

The SBLHC program is a limited program and only procedures or items that are listed on the Department's website are billable to the Department for reimbursement by the SBLHC. Refer to Topic S-202.5.

S-210.4 DIAGNOSIS CODES

All claims require a primary diagnosis code as listed in the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM).

S-221 PHARMACY SERVICES

The center may bill for injectable drugs and birth control devices only when they have been purchased by the center. CPT procedure code 99211 must be used for the actual “administration” of an injectable medication when the purpose of the visit is only to receive the injection.

S-221.1 Prior Approval for Oral and Injectable Drugs

Prior approval authorization is required for certain drugs covered by the Department’s Medical Programs. The SBLHCs must request prior approval for gamma globulin.

PRIOR APPROVAL PROCEDURE: To request prior approval, the center will need to complete a Request for Drug Prior Approval, Form DPA 3082*. The completed DPA 3082 must be faxed to the Drug Prior Approval Unit at (217) 524-7264 or (217) 524-0404. The center must provide the NDC code** and the State License Number of the administering practitioner at the time of the request. The center will receive a return fax within 24-hours (Monday - Friday) denoting the decision made on the request. If the request is approved, an eight-digit drug code will be provided to submit the claim for reimbursement.

*A copy of the form DPA 3082 may be obtained on the Department’s website at

<http://www.state.il.us/dpa/assets/applets/3082.pdf>

**The NDC code is located on the drugs’ vial or product information literature.

S-221.2 Hand Priced Injectable or Oral Drugs

Certain injectable drugs and devices are hand priced and require additional information when submitting a claim for payment.

- J1056 (Lunelle) - The name, strength, and dosage must be shown in 24C description area of the DPA 2360 claim form. This code is valid effective 1/1/02. For dates of service prior to 1/1/02 Lunelle must be billed using 90782 with the name, strength, and dosage entered in the description area.
- 90675 and 90676 (Rabies Vaccine) - The name, strength, and dosage must be

entered in 24C description area of the claim.

- 60009903 is to be used for oral contraceptives (birth control pills). The name of the birth control pill must be entered in 24C description area and the number of pills dispensed entered in 24F Days/Units field in a four-digit format. Only a three months supply can be dispensed at one time.

S-222 MEDICAL DIAGNOSTIC AND TREATMENT SERVICES

S-222.1 LABORATORY TESTS

Only those laboratory tests and examinations which are essential for diagnosis, evaluation and treatment are covered. Batteries of “rule out “ tests are not covered.

The center may charge only for those tests performed at the center using the center’s staff, equipment and supplies. When the patient presents for laboratory tests only, an office visit charge may not be made.

Centers providing laboratory services must be in compliance with the Clinical Laboratory Improvements Amendment (CLIA) Act. The center may not charge for laboratory tests performed by any outside laboratory. **Charges are not to be made when a specimen is obtained by center staff and sent out of the office.**

EXCEPTION: When a specimen is obtained by the center and sent to the Illinois Department of Public Health for lead screening, the provider may bill for the drawing fee. Refer to the fee schedule for the appropriate procedure code.